# PHS Actions for Building Capacity in Assessment

**Assessment: monitoring the health of the public.** Public health surveillance activities collect, assemble, analyze, use, and disseminate information about the health of the community on a regular and systematic basis. Assessment provides the framework for policy development.

The following are strategies for building capacity in assessment, with actions by agencies and representative examples. The two time periods shown are those during which the action either begins or continues, as for example, **1990–91** and **1992 and beyond.**

**Assessment strategy 1: Developing health information and health information systems that are useful to legislative and executive governmental bodies at the Federal, State, and local levels, and to other groups and organizations**

**Office of the Assistant Secretary for Health**

1. Coordinate PHS identification of baseline and future data sources and surveillance and data systems needed to track progress toward the Healthy People 2000 Objectives *(Office of Disease Prevention and Health Promotion)*.
**1990–91** **1992 and beyond**

2. Work with the New England Coalition for Disease Prevention and Health Promotion (NECON) to develop a standardized regional data base for evaluating progress in meeting regional health objectives and addressing future health needs. The data base will serve as a model for other regional data bases of its kind *(Office of Intergovernmental Affairs)*.
**1990–91** **1992 and beyond**

3. Cosponsor with the National Center for Health Statistics the oversampling of minorities in the National Maternal and Infant Health Survey in an effort to make more precise estimates of health problems of high-risk groups *(Office of Minority Health)*.
**1990–91** **1992 and beyond**

4. Encourage the development of adequate data surveillance systems to monitor morbidity and mortality rates, by condition; the adequacy of third party payor coverage; and access, availability, and utilization of services for minority populations *(Office of Minority Health)*.
**1990–91** **1992 and beyond**

5. Provide continued financial support and consultation regarding research questions to the National Center for Health Statistics' National Survey of Family Growth *(Office of Population Affairs)*.
**1990–91** **1992 and beyond**

**National Institutes of Health (NIH)**

1. Continue the development and utilization of large information bases on morbidity and mortality and identify and study associated risk factors. Examples of these responsibilities are listed.

**1990–91** **1992 and beyond**

- Large information bases on morbidity and mortality from cardiovascular, lung and blood diseases; prospective studies of cardiovascular diseases to identify characteristics of individuals that are associated with elevated risk;

- National Library of Medicine's (NLM) Directory of Information Resources On-line (DIRLINE), an on-line data base of information on locations and descriptive information about organizations that are considered to be information resource centers;

- Creation of the National Center for Biotechnology Information;

- Support of national data bases for assessing risk factors for morbidity, functioning, and institutionalization in an aging population;

- ARAMIS (Arthritis, Rheumatism, and Aging Medical Information System), a national chronic disease data bank system of parallel longitudinal clinical data sets. *National Institute of Arthritis and Musculoskeletal and Skin Diseases*

2. Support epidemiological and clinical research to study the origins, frequency of occurrence, and geographical distribution of infectious, allergic, chronic, environmental, and immunological diseases in humans. Representative activities are listed.

**1990–91** **1992 and beyond**

- Cancer;
- Multicenter prospective study of older Americans;
- Oral diseases and conditions and their prevention;
- AIDS;
- Hypertension prevention and control maintenance;
- Arthritis, musculoskeletal, and skin diseases;
- Lyme disease;
- Coronary heart disease;
- Environmentally related illnesses and dysfunction;
- Eye disorders and blindness.

3. Conduct studies of biomedical, behavioral, or environmental intervention. Examples of such studies are listed.

**1990–91** **1992 and beyond**

- Study of community-dwelling older Americans for functional status, mortality, and level of dependence;

- The National Cooperative Inner City Asthma Study to reduce morbidity for black and Hispanic children residing in the inner city;

- Surveillance and evaluation of behavioral aspects of cancer prevention and control;

- Study of behavioral intervention for reducing incontinence;

- American Stop Smoking Intervention Study (ASSIST).

4. Support research, development, and collaboration on data analysis of major health surveys, such as the National Health and Nutrition Examination Survey and the National Health Interview Survey.

**1990–91** **1992 and beyond**

- Examine the relationship of baseline clinical, institutional, and behavioral factors to subsequent morbidity and mortality;

- Sampling minorities and other populations for support of Healthy People 2000 Objectives.

5. Support multiple AIDS studies and surveys.

**1990–91** **1992 and beyond**

- Multi-Center AIDS Cohort Study;
- Heterosexual HIV Transmission Study;
- Epidemiologic studies of HIV infection;
- Women's and Infant's Transmission Study.

6. Support workshops and conferences to assist in assessing the status of public health efforts.

**1990–91** **1992 and beyond**

7. Assess the needs for research on health problems among special populations, and for related disease prevention and control programs. Groups that experience high mortality and morbidity rates, and underserved populations, include blacks, Hispanics, Native Americans, the aging, blue-collar groups, and low income groups. Research focuses on assessment of needs and design of interventions to address barriers and obstacles and to enable populations to reach full potential with regard to prevention and control.

**1990–91** **1992 and beyond**

8. Develop population-based registries to track disease incidence, patient survival, mortality, and geographic and demographic differences. Incidence, survival, and mortality can be studied to reveal factors associated with reductions in risk. Tracking systems are to include data on rural, black, and Hispanic populations.

**1990–91** **1992 and beyond**

• Surveillance of treatment and trends in cardiovascular disease through such programs as the Atherosclerosis Risk in Communities (ARIC) project of the Health and Vascular Diseases Program (*National Heart, Lung, and Blood Institute*);

• Surveillance, Epidemiology, and End Results (SEER) program of nine cancer registries (*National Cancer Institute*).

9. Monitor morbidity and mortality in other countries and support activities to standardize the examination and surveillance protocols to assure quality of the data, risk factors, and medical care.

**1990–91** **1992 and beyond**

• Multi-national Monitoring of Trends and Determinants in Cardiovascular Disease (MONICA), a project involving 27 countries (*National Heart, Lung, and Blood Institute*).

10. Provide surveillance and evaluation of behavioral aspects of disease prevention and control through supplements to National Health Interview Surveys.

**1990–91** **1992 and beyond**

**Indian Health Service (IHS)**

1. Complete a general plan for strengthening the information resource structure for the immediate years through 1994.

**1992 and beyond**

2. Write an implementation plan to improve assessment capacity and conduct research on prevention during the 5-year period from January 1991 through December 1995 and establish evaluation measures to document the success of the implementation plan.

**1992 and beyond**

3. Continue the implementation process of a uniform national data set.

**1992 and beyond**

• Define elements to be included in the IHS core data base, following satisfactory discussion and consensus between tribal leaders and IHS professionals and administrators.

• Assess the needs, including administrative structure, hardware, facility and personnel needs, to develop an infrastructure for effective management of the IHS core data base.

4. Establish a minimum programmatic data set.

**1990–91** **1992 and beyond**

5. Extend cancer registry strategies to two more IHS areas.

**1992 and beyond**

6. Initiate, with the National Center for Health Statistics (NCHS), an oversampling of urban American Indians and Alaska Natives in the National Prenatal Survey.

**1992 and beyond**

7. Analyze the results of blinded seroprevalence studies of HIV and provide results to participating tribal communities.

**1992 and beyond**

8. Establish a national fetal alcohol syndrome registry.

**1992 and beyond**

9. Establish a national registry of child neglect and abuse cases.

**1992 and beyond**

10. Establish a maternal and child health (MCH) data management group within IHS to review existing MCH data sets, assess additional MCH data needs (with particular attention to data needs to monitor progress in meeting Healthy People 2000 Objectives and P.L. 100-713, Sec. 714), and identify possible actions to meet the MCH data needs.

**1992 and beyond**

11. Release computer software that permits the direct entry of dental treatment data by local dental providers. Dental Data Software is a module of the Resource and Patient Management System (RPMS). By 1991, 20 percent of IHS and tribal dental programs will have established the capacity for software installation. By 1992 and beyond, more than 95 percent will have developed such capabilities.

**1990–91** **1992 and beyond**

12. Initiate the process of acquiring adequate computer systems for the larger facilities and upgrades for the data center and midlevel facilities.

**1990–91**

13. Define a set of core data elements and develop a format for an annual IHS dental program report form that will provide detailed information on program activities to tribal, Federal, regional, and local decision makers.

**1990–91**

14. Implement routine use of formal health risk appraisals in all age groups.

**1990–91** **1992 and beyond**

15. Establish IHS ambulatory patient care data as a Statistical Analysis System (SAS) data set accessible to IHS headquarters and field components.

**1990–91**

16. Develop a methodology to assess the maternal and child health needs and level of services, with particular attention to perinatal, prenatal, post partum, and well child care, in each IHS area and service unit.

**1990–91**

17. Establish well-designed studies of sudden infant death syndrome (SIDS) among American Indians and Alaska Natives.

**1990–91**

18. Develop, test, and release the dental resource management computer software component of the Resource and Patient Management System to IHS and tribal dental programs.

**1992 and beyond**

19. Coordinate appropriate research and development activities, contingent upon the availability of resources, for the implementation or revision of systems for management, operations, quality assurance, and information system development.

**1992 and beyond**

20. Develop, implement, and maintain a national community health reporting information system, obtain Office of Management and Budget clearance and the required resources, develop sampling plans, and plan and implement the necessary training to achieve program accountability.

**1992 and beyond**

21. Develop, test, and release oral epidemiology and community profile modules of dental Resource and Patient Management System computer software to local IHS and tribal dental programs.

**1992 and beyond**

22. Integrate the Community Health Reporting System II (CHRIS II) data collection system into the Resource and Patient Management System.

**1992 and beyond**

23. Develop and implement the Community Health Reporting Program resource allocation methodology.

**1992 and beyond**

24. Develop, test, and release a third party billing dental module of Resource and Patient Management System computer software to local IHS and tribal dental programs.

**1992 and beyond**

**Health Resources and Services Administration (HRSA)**

1. Collaborate with State and local public health agencies to develop health information systems to increase capacity to collect and analyze data on the health care needs of disadvantaged populations.

- Measure service needs of special populations, such as those in perinatal care, the homeless, substance abusers, the HIV-infected population, and

the elderly (*Bureau of Health Care Delivery and Assistance* and *Maternal and Child Health Bureau*).
**1990–91** **1992 and beyond**

• Conduct a series of activities designed to measure the need for health care services in rural areas (*Bureau of Health Care Delivery and Assistance*).
**1990–91**

• Coordinate efforts with the Institute of Medicine to develop a comprehensive study of pediatric emergency medical services (*Maternal and Child Health Bureau*).
**1990–91**

2. Work with State and local public health agencies and their national organizations to determine the resources available to direct care to the underserved populations in their area.

• Compile county level data where there is a local health department, community health center, or other subsidized facility, providing access to comprehensive primary care services for the underserved (*Bureau of Health Care Delivery and Assistance* and *Centers for Disease Control*).
**1990–91**

• Measure the adequacy of health manpower capacity, particularly in relation to a reduced National Health Service Corps.
**1990–91** **1992 and beyond**

• Determine provider mix and numbers and, by compiling profiles of health care providers, evaluate the capacity of community and migrant health centers to maintain or increase the number of users (*Bureau of Health Care Delivery and Assistance*).
**1990–91**

• Work with the National Association of County Health Officials (NACHO) and other groups to develop compendiums of innovative State and private sector activities in rural public health (*Office of Rural Health* and *Bureau of Health Care Delivery and Assistance*).
**1990–91**

3. Collect and analyze information on the supply and requirements of health professionals (*Bureau of Health Professions*).

• Collect and analyze information concerning the supply and requirements of professionals in the public health workforce. This effort has been initiated through the Healthy People 2000 Consortium.
**1990–91**

Included in this effort is (*a*) contracting with the Public Health Foundation of the Association of State and Territorial Health Officials to revise its ASTHO Reporting System to enable it to analyze the supply of and requirements for professionals in State health departments;
**1990–91**

and (*b*) collaborating with the Association of Schools of Public Health and the Centers for Disease Control to obtain and analyze data on local health department personnel, using the APEX/PH (Assessment Protocol for Excellence in Public Health). The project is a collaborative project funded through CDC and the National Association of County Health Officials.
**1990–91** **1992 and beyond**

• Focus on the supply of and requirements for the range of health professionals, particularly those that provide primary care.
**1990–91** **1992 and beyond**

Included in this effort is (*a*) giving particular attention within medicine to tracking the primary care specialties of family medicine, general internal medicine, and general pediatrics; (*b*) tracking progress in dealing with the shortage of nurses; and (*c*) collaborating with allied and associated health professions and organizations in developing estimates of supplies and requirements.

• Track those training needs that are particularly related to the maternal and child health program efforts.
**1990–91** **1992 and beyond**

4. Collaborate with the Agency for Health Care Policy and Research (AHCPR), as well as State and local public health agencies, to determine appropriate research to improve the organization and provision of services to disadvantaged populations.

• Maintain and strengthen support for research through discretionary grants under Special Projects of Regional and National Significance (SPRANS).

These research projects focus on developing new knowledge for application to the health problems of mothers, children, and children with special health care needs.
**1990–91** **1992 and beyond**

• Conduct cost comparisons to determine the effectiveness and efficiency of community health center systems.
**1990–91**

• Collaborate with AHCPR in enriching the research and knowledge development base in primary care services research (*Office of Planning, Evaluation, and Legislation*).
**1990–91**

5. Measure the clinical effects of intervention, measuring outcomes when feasible, or measuring intermediate outcomes. Intermediate outcome data are collected for each stage of the life cycle, such as perinatal, pediatric, adolescent, adult, and geriatric. Intermediate outcome measures include infant and childhood immunization rates, the receipt of routine prenatal care, and patient adherence to hypertension treatment. Examples of measuring intermediate outcomes are:

• Conduct an agency consensus conference on small area analysis for the purpose of better identifying and prioritizing needs in underserved areas (*Office of Planning, Evaluation, and Legislation*; and *Bureau of Health Care Delivery and Assistance*).
**1990–91**

• Continue to monitor Community and Migrant Health Center programs for compliance with intermediate outcome requirements through annual grant applications, midyear assessments, site visits, and routine submissions of data to the BHCDA standard reporting system.
**1990–91** **1992 and beyond**

Examples of outcome or health status measures are:

• Develop the capacity to collect and use health status data. The goal is to determine the health status of communities served by community and migrant health centers, the factors responsible for a community's health status, and the effect of the health delivery system on the community's health status (*Bureau of Health Care Delivery and Assistance*).
**1990–91**

• Improve clinical data on organ transplantation outcomes by contracting for continuing data collection by the Scientific Registry of Organ Transplant Recipients (*Maternal and Child Health Bureau*).
**1990–91**

An example of a measure of program effectiveness is:

• Develop and implement a strategy to utilize the evaluation program to carry out an effectiveness assessment of program performance for those programs proposing substantial budget increases *(Office of Planning, Evaluation, and Legislation*).
**1990–91**

**Food and Drug Administration (FDA)**

1. Expand existing research programs in the areas of biotechnology-derived products.
**1990–91**

2. Explore with consumer groups, academics, and industry the actual and perceived risk of the consumption of seafood.
**1990–91**

3. Start a systematic investigation of the role of diet on health, including its effects on the process of carcinogenesis, and coordinate work with other Federal and private sector activities.
**1990–91**

4. Assess the feasibility of developing a model program for a sentinel system for problem reporting in medical device post-marketing surveillance, within one or more medical school or university hospitals. The sentinel system could allow FDA to test the effectiveness of hospital reporting and to educate health care professionals concerning the need for problem reporting. (See assessment strategy 3, FDA item 2.)
**1990–91**

5. Continue efforts to improve the Medical Device Reporting data base by notifying firms of incomplete reports, issuing a guidance document that will clarify reporting requirements, and meeting with groups of device manufacturers on the need for such reporting.
**1990–91**

6. Continue to identify those segments of the population that may be at special risk from certain pathogens in food; and tailor and disseminate appropriate information for these groups to allow them to take appropriate precautions. (See assurance strategies 1, FDA item 15, and 6, FDA item 11.)

**1992 and beyond**

7. Intensify collaborative research efforts between FDA and industry to investigate the role of diet on health, including its effects on the process of carcinogenesis.

**1992 and beyond**

8. Develop and disseminate to industry information concerning the risks associated with migration of materials to food under actual use conditions, and suggested methods for reducing this risk. (See assurance strategy 1, FDA item 35.)

**1992 and beyond**

9. In the area of adverse drug reporting, increase from 5 to 10 the number of State health departments participating in the physician-based reporting pilot program.

**1992 and beyond**

10. Evaluate alternative medical device problem reporting methods and implement the most effective methods.

**1992 and beyond**

11. Implement a pilot alternative problem reporting program for medical devices. Alternative reporting is intended to reduce burdens on both FDA and industry while providing FDA with necessary information in a timely manner.

**1992 and beyond**

12. Enhance the Medical Device Reporting Program by adding sophisticated trend analysis that will allow earlier and more accurate identification of medical device problems.

**1992 and beyond**

**Centers for Disease Control (CDC)**

1. Identify and, as needed, develop data sources necessary to track and evaluate progress for the high priority health conditions, including the Healthy People 2000 Objectives.

• Convene internal and external work groups to identify data needs, existing data sources, ways to fill information gaps, especially those identified in each of the 22 priority areas of the Healthy People 2000 Objectives, and ways to build State and local assessment capacity.
**1990–91**

• Identify the resources required to gather more specific data on selected groups, such as for surveys to provide more detailed racial, ethnic, and socio-demographic group information.
**1990–91** **1992 and beyond**

2. Develop consensus among Federal, State, and local health departments, and other relevant organizations, on a complete set of common data elements for all of the high priority health conditions, including the Healthy People 2000 Objectives.

• Emphasize filling gaps in knowledge needed to respond to high priority problems.
**1990–91** **1992 and beyond**

3. Develop a set of health status indicators for use by Federal, State, and local health agencies.

• Initiate a process to develop health status indicators, a limited set of basic measures for use in a variety of health jurisdictions, concentrating on the needs at the local level to reflect overall morbidity, mortality, disability, and risk in the community.
**1990–91**

• Establish the use of a set of health status indicators by a majority of States.

**1992 and beyond**

4. Develop a set of public health system capacity indicators for use by Federal, State, and local health agencies.

• Develop, in collaboration with the Association of State and Territorial Health Officers, the National Association of County Health Officials, and the U.S. Conference of Local Health Officials, a sys-

tem to monitor the public health capacity of local health departments.
**1990–91** **1992 and beyond**

5. Incorporate the sets of common data elements for all high priority health problems into a coordinated public health surveillance system.

• Establish 10 regional centers for prevention and control of nosocomial infection linking about a thousand hospitals in a national surveillance network.
**1990–91** **1992 and beyond**

• Establish a county sentinel surveillance system for foodborne diseases.
**1990–91** **1992 and beyond**

• Establish mechanisms to collect the data through surveys and public health surveillance systems, and analyze and link data from existing data sets.
**1992 and beyond**

• Develop a nationwide, State-based system of chronic disease surveillance that integrates information about morbidity, mortality, disability, risk factors, use of preventive services, and health policies.
**1992 and beyond**

• Incorporate the modules of common data elements for priority areas of the Healthy People 2000 Objectives into PHS surveillance systems.
**1992 and beyond**

• Ensure tracking of progress towards meeting Healthy People 2000 Objectives among all appropriate population groups.
**1992 and beyond**

• Ensure the inclusion of occupational safety and health in CDC surveillance systems in the States.
**1992 and beyond**

• Obtain data needed to respond to identified problems, such as determining criteria to assess excessive human exposure to 50 toxicants of high priority.
**1990–91**

• Develop active public health surveillance systems in all States to assure rapid identification and reporting of diagnosed and suspected tuberculosis cases.
**1990–91**

• Develop blinded and nonblinded HIV seroprevalence surveys of people attending clinics for sexually transmitted disease, women's health, tuberculosis, and drug treatment.
**1990–91**

**Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)**

1. Design and implement the National Longitudinal Alcohol Epidemiologic Survey (NLAES) and analyze data from Wave 1. Continue NLAES and analyze Wave II and Wave III (*National Institute on Alcohol Abuse and Alcoholism*).
**1990–91** **1992 and beyond**

2. Design, implement, and complete a nationally representative study of the impact of alcohol abuse and alcoholism on short-term general hospital patients, the consequent costs, drinking-related accidents, and cirrhosis (*National Institute on Alcohol Abuse and Alcoholism*).
**1990–91** **1992 and beyond**

3. Design, implement, and complete a nationally representative longitudinal study of the characteristics of patients in alcohol and other drug treatment units and the specific contents of the treatment (*National Institute on Alcohol Abuse and Alcoholism*).
**1990–91**

4. Continue surveillance of cirrhosis mortality. Analyze the NCHS National Hospital Discharge Survey for cirrhosis and link the Hospital Discharge Survey with the Medical Provider Analysis and Review (MEDPAR) file to look at patterns of hospitalization for cirrhosis and comorbid conditions (*National Institute on Alcohol Abuse and Alcoholism*).
**1990–91** **1992 and beyond**

5. Analyze cirrhosis morbidity and mortality and contributing factors in NCHS's National Health and Nutrition Examination Survey, Epidemiologic Followup Study (*National Institute on Alcohol Abuse and Alcoholism*).
**1990–91** **1992 and beyond**

6. Convene experts in the epidemiologic, biomedical, and treatment research fields who are knowledgeable in cirrhosis mortality to analyze the factors contributing to the recent dramatic decreases

in cirrhosis mortality in the United States (*National Institute on Alcohol Abuse and Alcoholism*).
**1990–91**

7. Examine existing data bases to catalog factors involved in cirrhosis morbidity and mortality, so that a comprehensive research plan can be formulated (*National Institute on Alcohol Abuse and Alcoholism*).
**1990–91**

8. Analyze the Department of Labor, Bureau of Labor Statistics, National Longitudinal Survey of Youth-Child Data to determine the relationship of growth and development of offspring to maternal alcohol consumption during pregnancy (*National Institute on Alcohol Abuse and Alcoholism*).
**1990–91**

9. Provide grant support for research on maternal drinking at moderate levels of consumption during pregnancy and effects on the child (*National Institute on Alcohol Abuse and Alcoholism*).
**1990–91** **1992 and beyond**

10. Initiate the 1990 Longitudinal Followup of the 1988 National Maternal and Infant Health Survey of 11,000 mothers (5,000 white, 5,000 black, and 1,000 American Indian), conducted by the National Center for Health Statistics, to test the hypothesis that the mental and physical development of those 2 years old will show a direct correlation with maternal alcohol consumption during pregnancy (*National Institute on Alcohol Abuse and Alcoholism*).
**1990–91** **1992 and beyond**

11. Support research on the sequencing of alcohol, tobacco, and other drug use. Analyze the Bureau of Labor Statistics' National Longitudinal Survey of Youth-Child Statistics to determine early predictors of subsequent alcohol problems among young adults (*National Institute on Alcohol Abuse and Alcoholism*).
**1990–91** **1992 and beyond**

12. Support research on circumstances such as family circumstances in relation to alcohol use and abuse by young people, with the objective of achieving better understanding of changes in per capita consumption (*National Institute on Alcohol Abuse and Alcoholism*).
**1990–91** **1992 and beyond**

13. Support development of comprehensive data collection systems that meet both current and projected informational needs and provide baseline information to monitor and assess progress in meeting the Healthy People 2000 Objectives (*National Institute on Drug Abuse*).
**1990–91** **1992 and beyond**

14. Support and improve drug abuse surveillance and monitoring capabilities to provide mechanisms for developing, evaluating, and improving substance abuse and public health indicators (*National Institute on Drug Abuse*).
**1990–91** **1992 and beyond**

15. Continue funding support for the National Directory of Drug Abuse and Alcohol Treatment and Prevention Programs (*National Institute on Drug Abuse*).
**1990–91** **1992 and beyond**

16. Fund research to begin data collection in a nationally representative sample of persons with co-occurring mental and substance abuse disorders (*National Institute of Mental Health*).
**1990–91**

17. Fund four sites in a new program entitled "Cooperative Agreement for Methodologic Research for Multi-Site Epidemiologic Surveys of Mental Disorders in Child and Adolescent Populations" (*National Institute of Mental Health*).
**1990–91**

18. Initiate the National Reporting Program for Mental Health Statistics 1990 Inventory of Mental Health Organizations and General Hospital Mental Services and the 1990 Longitudinal Client Sample Survey of Outpatient Programs (*National Institute of Mental Health*).
**1990–91**

19. Initiate the feasibility assessment of modifications to the organizational data collection developed under a contract with the National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc. (*National Institute of Mental Health*).
**1990–91**

20. Implement the 1994, 1996, 1998, and 2000 National Reporting Program for Mental Health Statistics Inventory of Mental Health Organizations and

General Hospital Mental Services, incorporating revised data collection procedures determined through the contract with the NASMHPD Research Institute, Inc. (*National Institute of Mental Health*).

**1992 and beyond**

21. Fund research for data analysis and report to Congress on the national prevalence and health services utilization of those with co-occurring mental and substance abuse disorders (*National Institute of Mental Health*).

**1992 and beyond**

22. Participate in collaborative, interagency research to complete collection of information on affective disorders among young adults in a representative sample of the population (*National Institute of Mental Health*).

**1992 and beyond**

23. Conduct a 10-year update survey of severely disabled mentally ill persons who reside in U.S. households (*National Institute of Mental Health*).

**1992 and beyond**

24. Participate in review groups for the Mental Health Statistics Improvement Program and the National Reporting Program for Mental Health Statistics to assess progress made during the second half of the decade and to set objectives to be achieved by fiscal Healthy People 2000 (*National Institute of Mental Health*).

**1992 and beyond**

25. Finalize plans for making the 2000 decennial census data available to the mental health field (*National Institute of Mental Health*).

**1992 and beyond**

26. Maintain a National Clearinghouse for Alcohol and Drug Information as a national resource for up-to-date print and audiovisual materials about alcohol and other drugs (*Office for Substance Abuse Prevention*).

**1990–91** **1992 and beyond**

27. Monitor data from the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism to determine the scope and depth of alcohol and other drug problems in the United States (*Office for Substance Abuse Prevention*).

**1990–91** **1992 and beyond**

**Agency for Health Care Policy and Research (AHCPR)**

Support the design and development of new data bases and the enhancement of existing data bases for use in patient outcomes research and clinical decision making.

**1990–91** **1992 and beyond**

• Areas of support include (*a*) the development of uniform definitions for patient data, common reporting formats, data base linkages, and security and confidentiality standards; (*b*) investigation of the validity and accuracy of existing patient data; (*c*) representation of minority populations in data bases; and (*d*) promotion of wide access to these data.

**Agency for Toxic Substances and Disease Registry (ATSDR)**

1. Evaluate and develop health information materials on the nature of hazardous substances in the environment and their potential impact on public health.

**1990–91** **1992 and beyond**

• Examples include ATSDR Toxicological Profiles, case studies on the health effects of hazardous substances for the education of health professionals, and reports requested by Congress on subjects of environmental relevance.

2. ATSDR will develop and expand health information systems designed to capture and analyze information on the nature of chemicals in the environment and their potential impact on public health.

**1990–91** **1992 and beyond**

• Examples include ATSDR's Management Information System, containing environmental analyses of sites and the findings of health assessments, pilot and epidemiological studies, and toxicology; exposure and disease registries data systems; and hazardous substances data bases, such as those of the National Library of Medicine.